MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05045

CERTIFICATE OF DEATH

05043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH — a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 1 Day.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON (RURAL) X
d. STREET ADDRESS: —— 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: William — Middle: Richard. — Last: Bauer

4. DATE OF DEATH: Month: April — Day: 21 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: JUNE-27, 1887

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CORE MAKER

10b. KIND OF BUSINESS OR INDUSTRY: CORE MAKER

11. BIRTHPLACE (County & State, or foreign country): MASS.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: RICHARD BAUER

14. MOTHER'S MAIDEN NAME: WILHEMINA BACHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 022-05-3424

17. INFORMANT: MRS. GEORGE ROY — Address: N.Y. City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured Abdominal Aneurism — INTERVAL BETWEEN ONSET AND DEATH
4-5 1 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on Apr. 21, 19 62, and that death occured at 2:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E.C-H. Schmidt M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 22 April 1962

22c. PHYSICIAN'S NAME (Type): E.C-H. Schmidt — 22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE THEREOF: APR. 25, 1962 — 23c. NAME OF CEMETERY OR CREMATORY: SILVERBROOK CREMATORY — 23d. LOCATION (City, town or county) (State): WILMINGTON DEL.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice C Meconamy & Son — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: APR 24 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05046

CERTIFICATE OF DEATH

05044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN Hospital: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRASONVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Baxter

4. DATE OF DEATH: Month: April — Day: 28 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 25-62

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 3 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph A. Baxter

14. MOTHER'S MAIDEN NAME: Esther Lynn Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Jos. A. BAXTER: GRASONVILLE MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-25, 19 62 to 4-28, 19 62 that (I) (we) last saw the deceased alive on 4-29, 19 62, and that death occured at 6:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Donald F. Bartley M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4-30-62

22c. PHYSICIAN'S NAME (Type): Donald F. Bartley M.D.

22d. ADDRESS: Easton, Maryland 4-30-62

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-30-62

23c. NAME OF CEMETERY OR CREMATORY: Stevensville

23d. LOCATION (City, town or county) (State): Stevensville Md

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Edgar L. Jarrett Church Hill Md

25a. REC'D BY REGISTRAR — DATE: MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2-05 1654

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05047 05045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3 hrs. 25 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 EASTON
d. STREET ADDRESS: 305 NEEDWOOD AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Maude — Middle: Ethel — Last: Burkhardt

4. **DATE OF DEATH**: Month: 4 — Day: 25 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1884

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: 10 — Days: 8

IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Tinsley

14. MOTHER'S MAIDEN NAME: Sarah Chambers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 216-03-7461B

17. INFORMANT: Wm. J. Burkhardt — Address: 305 Needwood Ave Easton Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Unk
DUE TO (b): HASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..., 19..., to ..., 19..., that (I) (we) last saw the deceased alive on 4/25 1962 and that death occured at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. J. Eglestar M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/25/62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/27/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill

23d. LOCATION (City, town or county): Easton (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wallace Clark — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: APR 27 '62

25b. REGISTRAR'S SIGNATURE: Clarence J. Howard

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05048

CERTIFICATE OF DEATH

05046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: QUEEN ANNES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRASONVILLE RFD 2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA — Middle MAY — Last CHANCE

4. DATE OF DEATH: Month 4 — Day 29 — Year 1962

5. SEX: FEM.

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 13 1885

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Q.A. Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HANSON MORGAN

14. MOTHER'S MAIDEN NAME: ELLA DADDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. CLEM CHANCE — Address: GRASONVILLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
332X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary atherosclerotic heart disease & failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11 Apr 19 62 to 29 Apr 19 62 that (I) (we) last saw the deceased alive on 29 Apr 19 62, and that death occured at 4:30 P.M. DST, from the causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 30 Apr 62

22c. PHYSICIAN'S NAME (Type): THORSTON HARRISON

22d. ADDRESS: Carlow Mary Land

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/1/1962

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield

23d. LOCATION (City, town or county): Centreville (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill Md

25a. REC'D BY REGISTRAR DATE MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05049 **CERTIFICATE OF DEATH** 05047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 2 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 5 West St. 29 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Ruth — Middle: W. — Last: Dennis

4. **DATE OF DEATH**: Month: April — Day: 3 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 7, 1897

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George E. Warrington

14. MOTHER'S MAIDEN NAME: Salome D. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-20-5958

17. INFORMANT: Mrs Belle Dennis — Address: Easton Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Insufficiency (cause) — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Vascular disease (years)

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/6, 19 62 to 4/3, 19 62 that (I) (we) last saw the deceased alive on 4/1 19 62 and that death occured at 3:30 M, from the causes and on the date stated above.

22a. SIGNATURE: L. J. Eglester M.D.

22c. PHYSICIAN'S NAME (Type): L. J. EGLESETER

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/4/62

22d. ADDRESS: Easton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/6/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cem.

23d. LOCATION (City, town or county): Easton (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Maurice E. Newnam & Son Easton Md.

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Hicks

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05050

CERTIFICATE OF DEATH

05048

TO BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WITTMAN
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MD
   b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WITTMAN
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: PERRY Middle: H. Last: DYOTT, SR

4. **DATE OF DEATH**: Month: APRIL Day: 4 Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 15 1904

9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (County & State, or foreign country): EASTON MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Edward Dyott.

14. MOTHER'S MAIDEN NAME: MAY PAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-16-8530

17. INFORMANT: Mrs Effie M. Dyott Address: Wittman, Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 420.1

INTERVAL BETWEEN ONSET AND DEATH: 1 mo
1 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 19 62 to April 4 1962, that (I) (we) last saw the deceased alive on Jan. 1962, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Guy M Reeser M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): GUY M REESER SR

22d. ADDRESS: TILGHMAN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-7-62

23c. NAME OF CEMETERY OR CREMATORY: Christ Cemetery

23d. LOCATION (City, town or county): St Michaels (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. Hamilton Harrison

ADDRESS: St Michaels Md.

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Lurline S. Truma

1

FOR STATE HEALTH DEPT.

05051

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05049

1. PLACE OF DEATH
a. COUNTY TALBOT — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD (RURAL)
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.a Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b COUNTY TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford (Rural) x
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First EDWARD- Middle ALLEN, Last EASON
4. DATE OF DEATH Month april Day 7 Year 1962

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC. 22, 1961
9. AGE (In years last birthday) — yrs
IF UNDER 1 YEAR: Months 3 Days 1
IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXX
10b KIND OF BUSINESS OR INDUSTRY XXX
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME WILLIAM L- EASON
14 MOTHER'S MAIDEN NAME LULIA-ANDREW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX (If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO XXXX
17. INFORMANT Address William L Eason Oxford Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of Brain due to skull fracture
825 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto accident - head struck dash board
20c. TIME OF INJURY Hour 8:30 a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oxford Road
20f. (City or town) Easton (County) Talbot (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Thurston Harrison M D
EXAMINER'S NAME (Type) THURSTON HARRISON
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8 April 62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF April 10, 1962
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.
22d LOCATION (City, town, or county) Easton (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Minnie E. Newnam & Son ADDRESS Easton Md.
24a. REC'D BY REGISTRAR DATE APR 10 '62
24b REGISTRAR'S SIGNATURE Wilbur S. Hayes

1-00977

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any c... is necessary, please exec... certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 sha... forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
8M 2/57

1

FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05052

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05050

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
c. LENGTH OF STAY IN 1b: MARYLAND 7 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2. USUAL RESIDENCE (Where deceased lived, If Institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Tilghman
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: Benjamin Last: Ecker

4. DATE OF DEATH: Month: APR Day: 29 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-25-92

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Enginman-ret.

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aaron Ecker

14. MOTHER'S MAIDEN NAME: Emma Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): unk. unk.

16. SOCIAL SECURITY NO.: 705-07-6219

17. INFORMANT: George A. Ecker, Address Plaza 2 1734 Baltimore, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suicide by overdose sleeping pills
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): H.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis Welty M.D.

EXAMINER'S NAME (Type): WELTY

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4-29-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/3/62

22c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

22d. LOCATION (City, town, or country) (State): Tilghman, Maryland

23. FUNERAL DIRECTOR: W. Hampton Carroll

ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: MAY 1 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

W. Trampton Carroll

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05053 — 05051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN this MARYLAND place of death: 11 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. 2 Preston
   d. STREET ADDRESS: 24 N. Aspen Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Girl — Last: Ellerbe

4. **DATE OF DEATH**: Month: April — Day: 21 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 21, 1962

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: 11 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): MARYland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Ellerbe

14. MOTHER'S MAIDEN NAME: Helen Whittington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO. (If yes give war or dates of service): None

17. INFORMANT — Address: HelenWEllerbe - St. michaels

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 762.0 — focal atelectasis — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hyaline membrane disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from ..... 19 ..., to ..... 19 ..., that (I) (we) last saw the deceased alive on April 21 19 62, and that death occured at 1:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 22 April 1962

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-25-62

23c. NAME OF CEMETERY OR CREMATORY: Thomas Mem. Cem.

23d. LOCATION (City, town or county) (State): St. michaels, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Emma B. Bushell — ADDRESS: Easton md

25a. REC'D BY REGISTRAR DATE: APR 27 '62

25b REGISTRAR'S SIGNATURE: Arthur L. Kuhns

2-C 9-77

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05054

CERTIFICATE OF DEATH

05052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7-61

M

I

1. **PLACE OF DEATH**
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: 7 hrs 59 mins
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ~~TALBOT~~ CAROLINE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~EASTON~~ PRESTON
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby Boy — Middle: — Last: Ewing

4. **DATE OF DEATH**: Month: 4 — Day: 23 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April ~~25~~ 1962

9. AGE (In years last birthday): Months: — Days: — IF UNDER 1 YEAR: Hours: 7 — IF UNDER 24 HRS.: Min.: — Thus yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Francis Ewing Jr

14. MOTHER'S MAIDEN NAME: Margaret Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ~

17. INFORMANT: Father — Address: Preston Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

7 7 6X

INTERVAL BETWEEN ONSET AND DEATH: 7hr. 59 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 4-22-62, 19.., to 4-23-, 19 62, that (I) (~~we~~) last saw the deceased alive on 4-23- 19 62 and that death occured at 7:55A, from the causes and on the date stated above.

22a. SIGNATURE: Donald F. Bartley M.D

22b. DATE SIGNED: 4-25-62

22c. PHYSICIAN'S NAME (Type): Donald F. Bartley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Easton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: April 25 1962

23c. NAME OF CEMETERY OR CREMATORY: Wood Lawn Cem.

23d. LOCATION (City, town or county): And Easton (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: APR 27 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05055

CERTIFICATE OF DEATH

05053

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7,61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ida — Middle: Carter — Last: Favors

4. **DATE OF DEATH**: Month: April — Day: 21, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-15-04

9. AGE (If years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Nicholson

14. MOTHER'S MAIDEN NAME: Clara Aych

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-36-5285

17. INFORMANT: Address: Leon C. Favors, St. Michaels, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest due

603x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): to acute myocardial

DUE TO (c): injury & due to shock secondary to

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Nephrectomy

INTERVAL BETWEEN ONSET AND DEATH:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-17-62 to 4-21-62, that (I) (we) last saw the deceased alive on 4-21-1962 and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John N. Robinson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/23/62

22c. PHYSICIAN'S NAME (Type or print): John N. Robinson M.D.

22d. ADDRESS: Easton, Maryland 4/23/62

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-25-62

23c. NAME OF CEMETERY OR CREMATORY: Thomas Mem. Cem.

23d. LOCATION (City, town or county) (State): St. Michaels, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James B. Haskell

ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE APR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05056

CERTIFICATE OF DEATH

Items 3,4 &14 Filmed 4/9/62 iwk

05054

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN MARYLAND: 9 Years.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 1417 E. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter; Middle: Fenrich; Last: Feurich

4. DATE OF DEATH: Month: April; Day: 4; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 20, 1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired clerk

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (County & State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Feurich

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

(If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 055-10-9181

17. INFORMANT: Mrs. Wynne Feurich Address: Easton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): Coronary Artery Heart Dis — 6yrs

DUE TO (c): Generalized Arteriosclerosis — 10yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of Item 18.]

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..., 19..., to 4-4, 1962, that (I) ~~(we)~~ last saw the deceased alive on 4-4, 1962 and that death occured at 7:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 7, 1962

23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Mem. Park

23d. LOCATION (City, town or county): Kew Gardens (State): N. Y.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son

ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05057

CERTIFICATE OF DEATH

05055

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): EASTON
   c. MARYLAND — LENGTH OF STAY N 1b: 21 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Marydel
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: DENISE — Middle: LORRAINE — Last: HACKETT

4. **DATE OF DEATH**: Month: 4 — Day: 24 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 8, 1961

9. AGE (In years last birthday): yrs. 0 — IF UNDER 1 YEAR: Months 8 — Days 16 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Baskett

14. MOTHER'S MAIDEN NAME: Eva Hackett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): None

17. INFORMANT: Eva Hackett — Address: Marydel, Maryland

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO (b): Meningitis - H. Influenza.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 340.0

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/13 ....., 1962, to 4/24 ....., 1962, that (I) (we) last saw the deceased alive on 4/24 ..... 19 62 and that death occured at 3:13 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John E Baybutt

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: 4-27-62

22c. PHYSICIAN'S NAME (Type): JOHN E BAYBUTT

22d. ADDRESS: 205 Earle Ave EASTON, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-26-62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion

23d. LOCATION (City, town or county) (State): Marydel, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulais

ADDRESS: Greensboro, Md.

25a. REC'D BY REGISTRAR DATE MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kimmey

I-022149

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05058

CERTIFICATE OF DEATH

05056

1 PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels
c. LENGTH OF STAY IN 1b 1 wk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio-Vista Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) X McDaniel
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First ARTHUR Middle L. Last HARRISON
4 DATE OF DEATH Month April Day 27 Year 1962
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH MAY 26, 1873
9. AGE (In years last birthday) 88 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) St. Michaels, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Harrison
14. MOTHER'S MAIDEN NAME Susan Hambleton

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT Mrs Sara Crockett Address Oxford Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma prostate
177
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cachexia, uremia, pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 4-20 1962 to 4-27 1962 that (I) (we) last saw the deceased alive on 4-27 1962 and that death occurred at 4:58 P.M. from the causes and on the date stated above.

22a SIGNATURE Thomas Reese M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 4-29-62
22c PHYSICIAN'S NAME (Type) Thos M Reese Jr
22d. ADDRESS St Michaels Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried
23b. DATE THEREOF April 30-62
23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery
23d LOCATION (City, town, or county) St. Michaels. (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Hambleton Harrison, St. Michaels Md
25a. REC'D BY REGISTRAR DATE MAY 2 '62
25b REGISTRAR'S SIGNATURE Carthon L. Truma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05059

CERTIFICATE OF DEATH

Items 25c & d, Palm Coll 4/13/62 iwk

05057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOZMAN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EDWARD Middle: FRANK Last: JACKSON

4. **DATE OF DEATH**: Month: 4 Day: 7 Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 27 1883

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: SUMMER GUEST HOME

11. BIRTHPLACE (County & State, or foreign country): COATESVILLE, PA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: BENJIMAN JACKSON

14. MOTHER'S MAIDEN NAME: MARY MANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-32-0909

17. INFORMANT: Mary E. Jackson, Address: Bozman, Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b): pneumonia — 1 wk
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cachexia generalized.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 17 March 1962 to 7 April 1962 that (I) (we) last saw the deceased alive on 7 April 1962 and that death occured at 4 P M, from the causes and on the date stated above

22a. SIGNATURE: [signature] M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-9-62

22c. PHYSICIAN'S NAME (Type): Thos M Reed Jr

22d. ADDRESS: A Michaels md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 14-10-62

23c. NAME OF CEMETERY OR CREMATORY: Fair View Cem.

23d. LOCATION (City, town or county) (State): Coatesville, Penna

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Hamilton Harrison, St. Michaels Md.

25a. REC'D BY REGISTRAR DATE: APR 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05060

CERTIFICATE OF DEATH

05038

1 (M) I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Talbot — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Trappe — c. LENGTH OF STAY IN 1b: Life — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Talbot — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Trappe — d. STREET ADDRESS: — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Addison — Middle: — Last: Jenkins

4. **DATE OF DEATH**: Month: April — Day: 17 — Year: 1962

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: #Sept. 23, 1875

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Jenkins

14. MOTHER'S MAIDEN NAME: Elizabeth Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 215-26-5163

17. INFORMANT: George A. Jenkins — Address: Ph: La. 31, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 153.8 — Carcinoma of Colon

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease-Cardiac Decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 16...., 1962, to April 17...., 1962 that (I) (we) last saw the deceased alive on April 17, 1962, and that death occured at .... M, from the causes and on the date stated above.

22a. SIGNATURE: J. Edwin Fassett — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. Edwin Fassett, M.D. — 22d. ADDRESS: 227 Pine St., Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 4-21-62 — 23c. NAME OF CEMETERY OR CREMATORY: Sanderstown Cem. — 23d. LOCATION (City, town or county): TRAPPE (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James Braskell — ADDRESS: Easton, md.

25a. REC'D BY REGISTRAR DATE: MAY 2 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kirwan

VR A1S (4) 15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05061

CERTIFICATE OF DEATH

05059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- Easton
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 50

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before adm ssion)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- Easton
d. STREET ADDRESS: Route 50
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Nora — Middle: Matilda — Last: Jones

4. **DATE OF DEATH**: Month: April — Day: 11 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 19, 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (County & State, or foreign country): Talbot County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George T. Sinclair

14. MOTHER'S MAIDEN NAME: Rowena Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown): no

(If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: UKN.

17. INFORMANT: Curtis H. Jones, Route 50, Easton Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 43 A 1

DUE TO (b): Acute Myocardial Infarction

DUE TO (c): Complicated Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/14, 19 57 to 4/12, 1962, that (I) ~~(we)~~ last saw the deceased alive on 8/1, 19 61, and that death occured at 11:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. J. Egleder M.D

22b. DATE SIGNED: 4/12/62

22c. PHYSICIAN'S NAME (Type): L. J. Egleder

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 12 N. Hanson St., Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/14/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll

J. Frampton Carroll

ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: APR 17 62

25b. REGISTRAR'S SIGNATURE: C. Ross L. Mason

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05062

CERTIFICATE OF DEATH

05060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN MARYLAND: 31 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON,
   d. STREET ADDRESS: 308 S. WASHINGTON ST
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clifford — Middle: Bowen — Last: Jump

4. **DATE OF DEATH**: Month: April — Day: 1 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 26, 1881

9. AGE (If years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (County & State or foreign country): TALBOT, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN J. JUMP

14. MOTHER'S MAIDEN NAME: SUSAN E. SHANNAHAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 227-03-7845

17. INFORMANT — Address: MRS. NYTTLES S. JUMP, EASTON, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 527

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute Subdiaphragmatic Hemorrhage
DUE TO (c): Chronic Calculous Empyema

INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hyper Regenerating Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Surgery

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 1935 to April 1, 1962 that (I) (☒) last saw the deceased alive on April 1 1962 and that death occured at 7:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: L. J. Eglseder M.D.

22b. DATE SIGNED: 4/2/62

22c. PHYSICIAN'S NAME (Type): L.J. Eglseder, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: APRIL 3, 62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill

23d. LOCATION (City, town or county): Easton (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS: Easton, Md

25a. REC'D BY REGISTRAR DATE APR 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05063

CERTIFICATE OF DEATH

05061

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: 1 DAY
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XTRAPPE
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: S — Middle: TROTH — Last: Kemp

4. **DATE OF DEATH**: Month: APRIL — Day: 23 — Year: 1963

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 8, 1892

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER & FILLING STATION OWNER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): TALBOT MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ALFRED KEMP

14. MOTHER'S MAIDEN NAME: MARTHA HUGHLETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-24-4278

17. INFORMANT: Mrs NELLIE KEMP — Address: TRAPPE MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/23 19 63 to 4/23 19 62 that (I) (we) last saw the deceased alive on 4/23 19 62 and that death occured at 8:06 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/25/62

22c. PHYSICIAN'S NAME (Type): Thurston Harrison

22d. ADDRESS: Easton, Maryland

4/25/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: april 25, 1962

23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEM.

23d. LOCATION (City, town or county) (State): EASTON MD

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son — ADDRESS: Easton, md.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05064

CERTIFICATE OF DEATH

05062

1 (M) (I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH** a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN this place: 46 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Trappe
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Norman Middle: Haddaway Last: Leonard

4. **DATE OF DEATH**: Month: Apr. Day: 15 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Mar. 15, 1889

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cashier (Bank)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James M. Leonard

14. MOTHER'S MAIDEN NAME: Agnes Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No No

16. SOCIAL SECURITY NO.: 215-01-4658

17. INFORMANT: Address: Mrs Catherine Leonard Trappe Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 5 mo

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 181.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957 to April 15 1962, that (I) (~~we~~) last saw the deceased alive on Apr. 15 1962, and that death occured at 7:12 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William L. Winters M.D.

22b. DATE SIGNED: 4/17/62

22c. PHYSICIAN'S NAME (Type): William L. Winters

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: 210 E Dover Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 17, 1962

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cem.

23d. LOCATION (City, town or county) (State): Easton Md

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice F. Neuman & Son ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05065

CERTIFICATE OF DEATH

05063

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 8 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill 17x2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Chester — Middle: M. — Last: Massey

4. **DATE OF DEATH**: Month: Apr. — Day: 17 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 25 - 1901

9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM MANAGER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRISON D. MASSEY

14. MOTHER'S MAIDEN NAME: SARAH Mc WHORTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-01-7289

17. INFORMANT — Address: DOROTHY P. MASSEY - CHURCH HILL MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, right Lower lobe
DUE TO (b): Emphysema
DUE TO (c): Healed Pulmonary tuberculosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) this hospital attended the deceased from ..... 19.. to ..... 19....., that (I) (we) last saw the deceased alive on April 20 1962 and that death occured at 8:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt

22b. DATE SIGNED: 17 April 1962

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/20/62

23c. NAME OF CEMETERY OR CREMATORY: Church Hill

23d. LOCATION (City, town or county) (State): Church Hill Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Edgar L Sam

ADDRESS: Church Hill Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krug

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05065 05064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7,61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON.
c. LENGTH OF STAY IN 1b: 2 hr 5 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL DENTON
d. STREET ADDRESS: 5 X 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Wilford Middle: WALBERT Last: MORRIS

4. **DATE OF DEATH**: Month: April Day: 7 Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 4, 1910

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM OWNER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BRADFORD MORRIS

14. MOTHER'S MAIDEN NAME: MARY E. WALBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. **INFORMANT**: Mrs. WILFORD MORRIS, DENTON — Address

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction

DUE TO (b): Thrombosis left coronary artery.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... to ....., 19....., that (I) (we) last saw the deceased alive on April 10, 1962, and that death occured at 1:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E. C. H. Schmidt M.D

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS [X]

22b. DATE SIGNED: 7 April 1962

22c. PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22d. ADDRESS: Easton, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: APR. 10, 1962

23c. NAME OF CEMETERY OR CREMATORY: GREEN MOUNT

23d. LOCATION (City, town or county) (State): HILLSBORO, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Thompson ADDRESS: Denton

25a. REC'D BY REGISTRAR DATE: APR 13 '62

25b. REGISTRAR'S SIGNATURE: Catherine S. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05067

CERTIFICATE OF DEATH

05065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 7days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jasper — Middle: Matthew — Last: Neal

4. **DATE OF DEATH**: Month: April — Day: 1 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 4, 1888

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months: 6 — Days: 27 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bakery Employee

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Dorchester County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Neal

14. MOTHER'S MAIDEN NAME: Annie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 201-05-6441

17. INFORMANT: Mrs. Jasper Neal, Williamsburg, Maryland — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Emphysema

DUE TO

(c): Retroperitoneal Sarcoma

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19.., to ..... 19..., that (I) (we) last saw the deceased alive on ..... 19..., and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt — M D

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 1962

22c. PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22d. ADDRESS: Easton, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 4, 1962

23c. NAME OF CEMETERY OR CREMATORY: Washington

23d. LOCATION (City, town or county) (State): Near Hurlock, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. J. Hampton & Son — ADDRESS: Fredericksburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Catherine L. Thomas

VR A1S (4) 1SM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05068 — 05066

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST. MICHAELS (RURAL)
c. LENGTH OF STAY IN this MARYLAND place of abode: 3 WEEKS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RIO VISTA NURSING HOME

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: DEL. b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): REHOBETH
d. STREET ADDRESS: 36 WILMINGTON AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First M. Middle KEMP Last NEWNAM
4. **DATE OF DEATH**: Month APR. Day 30 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: FEB. 13, 1887
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): TALBOT Co. MD
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM BARTLETTE NEWNAM
14. MOTHER'S MAIDEN NAME: EDITH PARSONS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no no
16. SOCIAL SECURITY NO.: 214-32-6930
17. INFORMANT: M. Kemp Newnam Address: Elkton Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cachexia - severe
DUE TO (c): carcinoma prostate with

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): widespread metastases - stomach, liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-24, 1962 to 4-30, 1962 that (I) (we) last saw the deceased alive on 4-30 1962 and that death occured at P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas Reese Jr
22b. DATE SIGNED: 5-2-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Thos. M. Reese Jr
22d. ADDRESS: St Michaels Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 3, 1962
23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEM.
23d. LOCATION (City, town or county): EASTON (State): MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son. ADDRESS: Easton Md
25a. REC'D BY REGISTRAR DATE: MAY 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05069

CERTIFICATE OF DEATH

05067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7 61

1. **PLACE OF DEATH** a. COUNTY: Talbot — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — c. LENGTH OF STAY IN MARYLAND: 3 hours — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Pennsylvania — b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aldan — d. STREET ADDRESS: 43 S. Sycamore Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Julia — Middle: Hyatt — Last: Price

4. **DATE OF DEATH**: Month: April — Day: 22 — Year: 1962

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 2-2-1897 — 9. AGE (In years last birthday): 65 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier — 10b. KIND OF BUSINESS OR INDUSTRY: U. of P. Dental School — 11. BIRTHPLACE (County & State, or foreign country): New Castle Co. [illegible] — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Wesley Price — 14. MOTHER'S MAIDEN NAME: Rosa Lee Daubman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO.: 302-22-4432 — 17. INFORMANT: Elizabeth M. Price — Address: 43 S. Sycamore Ave Aldan, Pa

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ventricular fibrillation — DUE TO (b): Rheumatic heart disease months — DUE TO (c): [blank]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: sudden (?)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from... 22 Apr ..... 1962, to ..... 19....., that (I) (we) last saw the deceased alive on..... 22 Apr ..... 19 62, and that death occured at 9:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 22 Apr 62

22c. PHYSICIAN'S NAME (Type): HURSTON HARRISON — 22d. ADDRESS: Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 4-26-62 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington Cem. — 23d. LOCATION (City, town or county): Delaware Co (State) Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: APR 26 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05070

CERTIFICATE OF DEATH

05068

Information from birth cert.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e[illegible]ed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. PLACE OF DEATH
a. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN Md: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: Rt. #3 Box 44
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle: ; Last: Simpson

4. DATE OF DEATH: Month: April; Day: 21; Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APR. 19, 1962

9. AGE (If years last birthday) yrs.; IF UNDER 1 YEAR Months; Days: 2; IF UNDER 24 HRS. Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: MORRIS SIMPSON

14. MOTHER'S MAIDEN NAME: KATIE HILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: Morris Simpson Denton, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Endocardial Fibrosis
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/19, 1962, to 4/21, 1962, that (I) (we) last saw the deceased alive on April 21, 1962 and that death occured at 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D.

22b. DATE SIGNED: 22 April 1962

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 23, 1962

23c. NAME OF CEMETERY OR CREMATORY: Denton

23d. LOCATION (City, town or county) (State): Denton Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Wright Moore Son Denton

ADDRESS

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05071

CERTIFICATE OF DEATH

05069

1

(M)

80

(I)

6

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 16 hrs 10 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS: River Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MICHAEL — Middle: ALLEN — Last: STANLEY

4. DATE OF DEATH: Month: 4 — Day: 1 — Year: 1962

5. SEX: Male — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: February 23, 1962 — 9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 1 Days: 8 — IF UNDER 24 HRS.: Hours: — M.n.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mervin E. Stanley
14. MOTHER'S MAIDEN NAME: Erma Ricketts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Evelyn Ricketts — Address: Federalsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Malnutrition; Dehydration — 1 mo

DUE TO (c): Diarrhea — 1 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-31, 1962 to 4-1, 1962, that (I) (we) last saw the deceased alive on 4-1 19 62, and that death occured at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John E Baybutt M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-2-62
22c. PHYSICIAN'S NAME (Type): John E. Baybutt, M.D.
22d. ADDRESS: 205 Earle Ave EASTON, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 2, 1962
23c. NAME OF CEMETERY OR CREMATORY: Federal Hill
23d. LOCATION (City, town or county): Federalsburg, Maryland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. J. Frampton & Son — ADDRESS:
25a. REC'D BY REGISTRAR DATE: APR 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur B. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05072

CERTIFICATE OF DEATH

05070

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- Easton
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chapel Road

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural- Easton
d. STREET ADDRESS: Chapel Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Annie; Middle: X----; Last: Stinson

4. DATE OF DEATH: Month: April; Day: 26; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 28, 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? ~~USA~~ England

13. FATHER'S NAME: John W. Vesty

14. MOTHER'S MAIDEN NAME: Elizabeth Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: 218 20 4049

17. INFORMANT: Mrs. Jessie Voshell, Address: Easton, RD, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary artery diseasewith myocardial insufficiency

DUE TO (b): Hypertensive cardio-vascular disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: more then ten years / 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 20 ..., 19 47 to April 26 19 62 that (I) (we) last saw the deceased alive on. April 26 1962 ., and that death occured 11.11 M, from the causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Kurt L. Lederer MD

22d. ADDRESS: Queen Anne, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/62

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Hillsboro, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll
T. Frampton Carroll

ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05073

CERTIFICATE OF DEATH

05071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 .41
15M 7 61

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 61 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 416 South St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Thomas — Last: (Thomas)

4. DATE OF DEATH: Month: April — Day: 30 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 30, 1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Talbot Co. md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Perry Thomas

14. MOTHER'S MAIDEN NAME: Lucinda Coursey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-09-3870

17. INFORMANT: Novella Thomas — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Encephalopathy
DUE TO (b): Hypertensive Cardiovascular Renal
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

INTERVAL BETWEEN ONSET AND DEATH: 7 days / 5 yrs.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 28 April 1962 to 30 April 1962 that (I) (~~we~~) last saw the deceased alive on 30 April 1962 and that death occured at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D.

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: MAY 5, 1962

23c. NAME OF CEMETERY OR CREMATORY: Richards Cem.

23d. LOCATION (City, town or county): Easton, (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James Bothell — ADDRESS: Easton, md

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Cinthia L. Truma

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05074

05072

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton 29
d. STREET ADDRESS: Clifton 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Perry — Middle: E — Last: Wightman

4. **DATE OF DEATH**: Month: April — Day: 30 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1905

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mfg. Electronic Equipment

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Mt. Rainier Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Wightman

14. MOTHER'S MAIDEN NAME: Bernice Duffelo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 577-05-0730

17. INFORMANT: Mrs. Lillian Wightman — Address: Easton Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4/28/62
332 X
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Intracranial Neoplasm not ruled out — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/26, 1962, to 4/30, 1962, that (I) (we) last saw the deceased alive on 4/30, 1962, and that death occured at 6:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: L. J. Eglseder M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/30/62

22c. PHYSICIAN'S NAME (Type): L. J. Eglseder M.D.

22d. ADDRESS: Easton, Maryland 4/30/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3, 1962

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial P.K.

23d. LOCATION (City, town or county): Easton (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Leonard & Son — ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05075

CERTIFICATE OF DEATH

05073

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt 4 Easton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): X

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Easton
d. STREET ADDRESS: Rt. 4 - Box 62
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Minnie — Middle: A. — Last: Wisher

4. **DATE OF DEATH**: Month: 4 — Day: 11 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 7, 1906

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: House wife

11. BIRTHPLACE (County & State, or foreign country): MARyland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Bailey

14. MOTHER'S MAIDEN NAME: MARY E. Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-6301

17. INFORMANT — Address: William W. Wisher

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage from left middle cerebral Artery — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Hypertensive Encephalopathy — 2 yrs
DUE TO (c): Hypertensive Cardiovascular Disease — Many yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 43 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1953 to 4/10, 1962 that (I) (we) last saw the deceased alive on 4/10 1962 and that death occured at 3:38 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Shepard Krech M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/13/62

22c. PHYSICIAN'S NAME (Type): Shepard Krech Jr

22d. ADDRESS: EASTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-15-62

23c. NAME OF CEMETERY OR CREMATORY: Sanderstown Cem.

23d. LOCATION (City, town or county): TRAPPE (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James Burchiel - Easton, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61